DEPO-PROVERA EVALUATION

Name T	Today's Date	
Date last menstrual period started:		
Describe menstrual pattern on Depo:		
Date of last Depo injection (shot):		
Check if you are having any of the following:		
Headaches (different or more severe since state) Dizziness	arting Depo)	
Blurry or double vision		
Severe depressionHeavy bleeding from the vaginaWeight gain		
Frequent urination, breast tenderness, or other signs of pregnancy		
Do you have any questions about Depo-Provera?		
Are you taking any other medication? Any other comments: How many months/years have you been using Depo Prove		
Client Signature	ia:	Date
Cheff Signature		Date
TO BE COMPLETED BY CLINIC STAFF		
If client has been receiving Depo Provera for more than 2 discussion of risk/benefits of continued use: ☐ discussed ☐ not discussed because: ☐ Client wishes to:		
□ continue Depo use: Rx	_ Given:	Lot #
☐ discontinue Depo/change to:	*	cation)
Wt: B/P: Other:		
Return to clinic: 12 Wks: or Other Date:		
Staff Signature		Date